

<b>Case Number:</b>	CM14-0203298		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	01/01/2000
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 51 year old man sustained an industrial injury on 1/1/2000. The mechanism of injury is not detailed. Evaluations have included lumbar x-rays showing grade one lytic listhesis at L5-S1 and lumbar MRI showing the same lytic listhesis, severe foraminal narrowing, more so on the right, and posterolateral protrusion on the right side. Treatment has included oral medications and physical therapy. Physician notes dated 11/11/2014 show the worker experiencing back pains since 2000 that has been chronic and fairly tolerable. However, since March 2014, the pain became worse and incapacitating making him unable to work. The worker states the pain is in the low back with radiation to the bilateral lower extremities, worse on the right with weakness to the lower extremities and worsens more when walking. The physical examination showed pain with lumbar extension and relief with flexion. Recommendations include epidural injection to the bilateral L5-S1 as well as a pars interarticularis block bilaterally over the lytic defect at L5. Physician notes dated 11/17/2014 show no changes in condition, medication refills, and mention that the worker is to start physical therapy. There is notation of waiting approvals for the requested facet injection. He is considered temporarily totally disabled. On 11/19/2014, Utilization Review evaluated a prescription for bilateral L5 facet injection. The UR physician noted that the worker was receiving the bilateral L5 facet block on a diagnostic basis for radicular pain. The request was denied and subsequently appealed to Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

## **Bilateral L-5 Facet Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According MTUS guidelines, Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain>. According to ODG guidelines regarding facets injections, under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial.>. Furthermore and according to ODG guidelines, < Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time.5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no clear evidence that lumbar facets are the main pain generator or evidence of efficacy of previous medial branch block. The patient have evidence of radicular pain. Therefore, the request for Bilateral L-5 Facet Injection is not medically necessary.